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Health Services

ADMINISTERING AEROMEDICAL STAGING FACILITIES

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This directive implements Air Force Policy Directive (AFPD) 44-1, *Medical Operations,* by providing guidance and instructions (to include US Air Force active duty, ANG and Reserve forces) for establishing and managing an Aeromedical Staging Facility (ASF)/Aeromedical Staging Squadron (ASTS). It defines the ASF mission and scope of care; explains how to manage and transport patients; and specifies support responsibilities of the medical treatment facility (MTF). Refer to Contingency Aeromedical Staging Facility (CASF) AFTTP 3-42.53. It is to be used in conjunction with Air Force Instruction (AFI) 41-301, *Worldwide Aeromedical Evacuation System,* AFI 41-303, *Aeromedical Evacuation Dietetics Support,* AFI 41-307, *Aeromedical Evacuation Patient Considerations and Standards of Care,* AFH 41-318, *Ambulance Bus (AMBUS) Training Standards,* and Joint Pub 4-02.2, *Joint Tactics, Techniques, and Procedures for Patient Movement.* For additional guidance**, see:** *AFTTP 3.42.5 Aeromedical Evacuation;* AFI 10-206, *Operational Reporting,* AFMAN 10-100, *Airman's Manual,* AFMAN 23-110, *USAF Supply Manual,* AFI 41-309, *Aeromedical Evacuation Equipment Standards, AFPAM 10-219v5, Bare Base Conceptual Planning Guide,* AFH 10-222v1, *Guide to Bare Base Development,* AFI 46-101, *Nursing Services and Operations,* AFPD 10-7, *Information Operations (OPSEC) Instructions,* AFJMAN 24-306, *Manual for the Wheeled Driver,* AFI 31-304, *Enemy Prisoner Of War, Retained Personnel, Civilian Internees And Other Detainees* and AR 190-8, *Enemy Prisoners of War,* AFMAN 32-4005, *Personnel Protection and Attack Actions,* AFPD 34-5, *Mortuary Affairs,* and AFMAN 24-204, *Preparing Hazardous Material for Military Shipmen,*. Send comments and suggested improvements on AF Form 847, Recommendation for Change of Publication**,** through channels to HQ AMC/SGX 203 West Losey Street, Suite 1610, Scott AFB IL 62225-5219. Ensure that all records created as a result of processes prescribed in this publication are maintained in accordance with AFMAN 37-123, *Management of Records* and disposed of in accordance with the *Air Force Records Disposition Schedule* (RDS) located at **https://afrims.amc.af.mil**.

SUMMARY OF CHANGES

Changes involve aligning the mission and responsibilities of the CASF to reflect the current AFTTP 3.42.53. It also describes the CASF capabilities and configurations, adjusts the scope of care and functions of the CASF, phases of deployment and updates forms, abbreviations and acronyms.

Chapter 1

AEROMEDICAL STAGING FACILITY COMPOSITION

1.1. Mission. The Aeromedical Staging Facility (ASF) Mission.

1.1.1. The ASF has a two-fold mission: To provide support and continuity of medical care for patient movement and serve as an integral link in the Global Aeromedical Evacuation system. NOTE**:** The ASF has no surgical, lab, dental, x-ray or blood bank capabilities. It is designed for short-term complex medical-surgical nursing care and limited emergent intervention. Critically ill patients will receive care at the nearest MTF or by the Critical Care Air Transport Teams (CCATT) at the ASF while awaiting airlift.

1.1.2. Patients with active Global Patient Movement Requirements Center (GPMRC) or Joint Patient Movement Requirement Center (JPMRC) cite numbers and medical/non-medical attendants may transit through the ASF.

1.2. Types of ASFs. There are three types of ASFs: Fixed, Contingency, and Mobile.

1.2.1. Fixed: A Fixed ASF (FASF) is a permanent facility and may be co-located or geographically separated from a permanent MTF, and as such will require administrative and logistical support from that treatment facility. The FASF will support current contingencies by expanding resources used during peacetime operations. FASF personnel provide complex medical-surgical nursing care and administrative processing in accordance with Department of Defense (DOD), Air Force (AF) standards of health care.

1.2.2. Contingency: A Contingency ASF (CASF) is a modular and expeditionary concept that supports the full spectrum of contingency operations including Operational Plans (OPLANS), the Integrated CONUS Medical Operations Plan (ICMOP), Homeland Defense (HLD), and Humanitarian Relief Operations (HUMRO) at the time of execution. (Logistics and designated equipment, are capable of sustaining 24-hour operations). CASFs are staffed with medical, administrative and logistics personnel - including designated equipment - that is capable of sustaining 24-hour operations. Equipment and personnel Unit Type Codes (UTC) assigned to Reserve and Active Duty units will provide capabilities to operate CASFs of given bed capacities. Employed CASFs coordinate with all service medical and transportation elements to accomplish patient movement. CASFs provide patient reception, complex medical-surgical nursing care, limited emergent intervention and ensure that patients are medically and administratively prepared for medical evacuation**.** Patients requiring extensive medical treatment or critical nursing care will remain in the MTF until arrangements have been made for transfer.

1.2.3. Mobile: A Mobile ASF (MASF) is a deployable, tented asset for temporary staging, casualty care and administration support during contingency operations. It is located near runways or taxiways of forward air heads, operating bases used by tactical airlift or designated transportation hubs. This mission is to support the tactical interface between service MTFs and medical evacuation. MASF holding capability is 2-6 hours for patients entering the patient movement system. The MASF requires logistical and administrative support from the supporting base. (MASFs do not have physicians).

1.3. ASFs. Aside from the fixed ASF, the CASF or MASF may operate from buildings of opportunity or tents (See **Attachment 2**) to support the AE/patient movement mission and is usually located on or near

an airfield in close proximity to an aircraft-parking ramp. ASFs provide personnel and equipment necessary for 24-hour staging operations, patient transportation to aircraft and administratively processes patients transiting the AE system worldwide. The ASF coordinates and communicates with medical and transportation elements to accomplish patient care and patient movement, including ground transportation for patients entering, transiting, or leaving the AE system.

1.3.1. The ASF can be co-located with an MTF, but may be geographically separated to support AE mission requirements. If the distance from the MTF to ASF is determined by the Chief of Medical Services to be significant, emergent care personnel, (such as a CCATT) may be co-located with the ASF to assist in stabilizing patients. NOTE: If geographically separated, the ASF will require administrative and logistical assistance from supporting bases or service agencies. (i.e. orderly room, base supply etc.

1.3.2. The ASF is a key healthcare component of the AE or other medical evacuation resources. It provides holding capability for patients transiting the patient movement system. NOTE: The length of stay in the ASF may be from 24-72 hours.

1.3.3. The CASF/MASF utilizes War Reserve Materiel (WRM) supply and equipment assets that may be pre-positioned. The ASF deploys with an initial 7 day supply of expendable items. Expeditionary Medical Logistics provides timely re-supply of ordered items to deployed medical units. Orders will flow from the deployed unit through the Operations Group to the CONUS Sustaining Base. The CONUS Sustaining Base receives orders from deployed units and takes necessary actions to ensure 100% of all orders are transmitted to vendors/depots, are immediately purchased, packed, marked, and shipped so that the materiel is received by the deployed unit. Once the theater has sustained operations, the Single Integrated Medical Logistics Management (SIMLM) system will become the source for joint medical supply needs. (Fixed ASFs will be supported by the base MTF).

1.3.4. Depending on the type of ASF, the ASF personnel include flight surgeons, nurses, medical technicians, medical logistics technicians, mental health nurses and technicians, pharmacy technicians, nutritional medicine technicians, and biomedical repair personnel.

1.4. Operations. The ASF may be located at major AE/medical evacuation interface points within the theater at tactical or strategic air hubs. Upon notification of impending deployment, the commander of the deploying ASF will coordinate with the Medical Readiness Officer and accomplish a pre-deployment review of key documents and responsibilities. The Execution Order (EXORD)/Operational Order (OPORD) identifies Operational Control (OPCON), Tactical Control (TACON), Administrative Control (ADCON), mission objectives, rules of engagement, force protection, handling of classified information, hazardous cargo, and other mission specific requirements for the deployment. The theater combatant commander's redeployment order authorizes the redeployment of medical resources.

1.5. Interface with Medical Treatment Facilities (MTF). Upon arrival at the deployed location, the command element of the ASF (Commander, Chief of Medical Services, Administrator, and Chief Nurse) will contact appropriate Patient Movement Requirements Center (PMRC), sister service tactical evacuation assets/units, and shall attempt to contact all MTFs that will be moving patients to the ASF to ensure transportation and continuity of patient care is maintained. In addition to medical relationships, the Base Commander and Airfield Manager should be contacted to coordinate Base Operating Support (BOS) e.g. Air Transport Operations Center (ATOC), Civil Engineering, Communications, Transportation, Dining

Facilities (DFAC), flight safety, and Fire and Force Protection units should be notified of the presence of an ASF on the base.

1.6. Medical Reports and Communication. All medical intelligence reports are submitted in accordance with AFI 10-206, *Operational Reporting* and specific combatant commander, Joint Task Force (JTF) and Air Force Forces (AFFOR) guidance.

1.6.1. The Medical Readiness Contingency Report (MEDRED-C) is a status report for emergencies, disasters and contingencies. This report is accomplished daily and communicated to the AFFOR surgeon, contributing Major Command (MAJCOM) surgeons and the AF Surgeon General. It is an on-site assessment of the deployed medical unit's ability to complete its mission. This report provides information on the operational readiness status, unit availability, and patient care activities of Air Force Medical Service (AFMS) units on alert for contingency operations or which have come under the influence of an unusual occurrence (natural disaster or other emergencies). Refer to AFI 10-206, *Operational Reporting*.

1.6.2. The Situation Report (SITREP) will be completed by the deployed medical commander (senior medical officer) to provide daily medical input for inclusion in the deployed wing's SITREP. Data is used to make operational decisions on medical support forces and to perform medical intelligence analyses during contingency operations. FASFs, CASFs and MASFs may be required to provide information for this report. Refer to AFI 10-206, *Operational Reporting*, Chapter 4 for further guidance.

1.7. Scope of Care. ASFs are an intermediate level of care facility. Critically ill patients will be cared for at either the nearest medical treatment facility with required capability or on a short-term basis by CCATT at the ASF location for patients awaiting airlift. ASF personnel provide complex medical-surgical nursing care and administrative processing for all patients transiting the AE system. ASF personnel will:

1.7.1. Stage, enplane and deplane patients

1.7.2. Receive regulated patients and provide continuing and supportive care

1.7.3. Prepare and "clear patients for flight" to ensure suitability for AE under the guidance of the PMRC validating flight surgeon

1.7.4. Brief patients and accomplish appropriate documentation and TRAC^{2}ES inputs

1.7.5. Provide ground transportation between the ASF and the aircraft

1.7.6. Provide facility security for the protection of assets, personnel and entry control

Chapter 2

GENERAL ROLES AND RESPONSIBILITIES

2.1. Commander ASF.

2.1.1. Coordinates with the supporting three digit or higher MTF Commander, Aerospace Medicine Squadron/flight surgeon, and validating flight surgeon regarding care and services required for patient movement.

2.1.2. Develops and coordinates plans with the MTF, Wing, MAJCOM and the Global Patient Movement Requirements Center (GPMRC), Theater Patient Movement Requirements Center (TPMRC) or Joint Patient Movement Requirement Center (JPMRC) and Aeromedical Evacuation Control Team (AECT) to support peacetime and contingency operations.

2.1.3. Ensures ASF training is provided to all assigned personnel.

2.1.4. Assesses overall personnel demands against authorized/allocated resources.

2.1.5. Ensures ASF funding and accountability by submitting requirements to MTF or co-located medical facility for budget and financial planning.

2.1.6. Supports and oversees personnel management of unit.

2.2. Chief of Medical Services.

2.2.1. Provides oversight to flight medicine, pharmacy, and nutritional medicine including assigned psychiatric and mental health credentialed providers. (Acknowledgement: there are no providers in a MASF).

2.2.2. Provides final authority determination of patient status as admitted or authorized to Remain Over-Night (RON) in the ASF.

2.2.3. Supervises and directs the utilization of resources allocated to the ASF, including Behavioral Health, Rapid Response Team and CCATT assets.

2.3. Chief Nurse/Nurse Manager.

2.3.1. Provides clinical oversight and management of Nursing Services, to include Mental Health nurses and technicians.

2.3.2. Assesses nursing personnel demands against authorized/allocated resources.

2.4. Chief of Health Services Management.

2.4.1. Provides oversight to Medical Control Center (MCC) personnel, logistics, biomedical equipment repair, facility manager, security, transportation personnel and disaster response planning and coordination.

2.5. Pharmacy.

2.5.1. Prepares patients medications for departure from the ASF.

2.5.2. Obtains and provides pharmaceuticals within the approved ASF formulary which may or may not be augmented by medications provided by the MTF or other available resources.

2.5.3. Assures or provide patients with an adequate supply of medications to reach their prescribed destination. (Intra-theater movement requires a 3-day minimum supply; whereas, inter-theater movement requires a 5-day minimum supply).

2.5.4. Originating MTF will ensure patient medication education for any prescribed pharmaceuticals.

2.5.5. Physicians are required to have two AF Form 2383 – *Prescriber's Information Card* on file (one at MTF pharmacy, one with ASF pharmacy tech). Nurses are required to have one AF Form 2383 on file in the ASF pharmacy.

2.5.6. Provide AF Form 579 – *Controlled Substance Register* is used to dispense narcotics to different nursing stations. (A separate form is needed for each controlled substance and dosage).

2.5.7. Reviews the ASF Table of Allowances Formulary and tailor according to local requirements, IAW local policy. The formulary must be approved by the MDG/CC.

2.6. Nutritional Medicine Support.

2.6.1. Nutritional Medicine coordinates patient feeding requirements with BOS Elements. Nursing service orders patient meals three to four times a day on AF Form 1094, *Diet Order*. The form is completed by Nursing Services – all patients must be annotated on the diet order form. The patient meal tally is to be presented to the Dining Facility (DFAC) no later than 2 hours prior to the start of meal preparation. Patient feeding requirements are coordinated with DFAC, flight kitchen, and Nutritional Medicine. The AF Form 129, *Tally in/out* is used to transfer rations from an AF dining facility or MTF. The AF Form 79, *Cash Collection Record* is used to account for patient meals prepared in an Air Force dining facility.

2.6.2. ASF directs or provides meals to patients transiting the patient movement system. Attendants (medical and non-medical) are authorized to use MTF dining facilities when available at their own expense. The ASF provides meals to patients using local dining facilities or Meals Ready to Eat (MRE). Refer to AFI 41-115, *Authorized Health Care and Health Care Benefits in the Military Health Services System (MHSS),* and AFI 41-303, *Aeromedical Evacuation Dietetic Support,* for additional information regarding meals.

2.6.3. Inform Nutritional Medicine at the MTF of any unique food requirements. In the event of altered transportation plans, the ASF shall obtain adequate nutritional provisions for patients and shall obtain and provide 3-day tube feeding supply for intra-theater patient movement and 5-day supply for inter-theater movement.

2.7. Transportation.

2.7.1. ASFs are responsible for the transportation of patients between their facility and the evacuation asset. Depending upon the patient's needs, a nurse, medical technician, and health service technician (in addition to the driver), plus emergency equipment may accompany patients in an Ambulance Bus (AMBUS), ambulance or vehicles of opportunity according to patient requirements. ASF personnel are also required to load and unload patients on and off aircraft or other evacuation asset. Additional medical personnel may be required due to patient acuity.

2.7.2. The ASF commander will appoint a Vehicle Control Officer/Non-Commissioned Officer (VCO/VCNCO) in writing. The VCO/VNCO will manage the vehicles in accordance with AFI 24-301, *Vehicle Operations*, AFI 23-302, *Expeditionary Vehicle Management*, AF Handbook 24-320, Guide to Vehicle Operations in an Expeditionary Environment and local directives. The VCO/VNCO will ensure appropriate ASF personnel are trained to operate assigned vehicles and will verify certification for flight line vehicle operations. The VCO/VCNCO will prepare and submit vehicle reports according to local directives.

2.8. Administration.

2.8.1. The senior Medical Service Corps (MSC) officer and administrative staff are responsible for coordinating patient movement with originating/supporting MTF(s), GPMRC, TPMRC or JPMRC, as well as managing ASF functional operations and establishing plans, policies, processes, and procedures. They will:

2.8.1.1. Maintain, in accordance with Air Force and local directives, a comprehensive Events Log documenting activities, correspondence, communications and facility issues. The events log provides historical documentation of all activities within the facility and should the need arise can be used to verify activities, as well as actions taken by unit personnel.

2.8.1.2. Maintain a Status Board displaying appropriate information, such as mission, Estimated Time of Arrival (ETA), Estimated Time of Departure (ETD), patient loads, and aircraft data.

2.8.1.3. Verify mission information, including patient information, load data, special equipment requirements and aircraft information with appropriate agencies as directed by higher headquarters and local directives. Coordinates patient and mission changes with appropriate Patient Movement Requirements Center and with Aeromedical Evacuation Control Team (AECT) to ensure lift and crews are appropriate for mission.

2.8.1.4. Coordinate mission requirements with appropriate ASF personnel, such as census, launch and recovery times/staffing needs, to include drivers or vehicles, appropriate clinical points of contact at other MTFs and supporting agencies.

2.8.1.5. The physician at the originating facility will initiate appropriate documentation and sign the AF Form 3899, *Patient Movement* recommending aeromedical evacuation of patients and attendants. ASF clinical staff will document patient assessment and care, while ASF administrative staff will ensure documentation is available for use. Patient Administration or Medical Regulating Office will provide appropriate documentation from TRANSCOM Regulating And Command & Control Evacuation System ($TRAC^2ES$) to meet mission requirements, such as Patient Movement Request (PMRs), Patient Manifest, and Patient baggage list. AF Form 3899s and Standard Form 600s, *Health Record--Chronological Record* will be available for ongoing documentation of patient care. The flight surgeon clears the patient for flight and documents appropriately. Assure process is coordinated with local security forces to store/dispose of weapons or ammunition which cannot be returned to the patient's unit.

2.8.1.6. Ensure patients and attendants are briefed regarding ASF policies and procedures, including at a minimum, force protection issues, unauthorized items in the facility, as well as on aircraft and anti-hijacking requirements. Unauthorized items will be confiscated and documented on AF Form 1297, *Temporary Issue Recipt*. Weapons and ammunition, whenever possible, should be

given to the patient's unit for storage and/or return to home station, with appropriate documentation in the Events Log or on an AF Form 1297.

2.8.1.7. Ensure patient accountability is maintained and MCC is informed of patient census at all times. Patient accountability can be maintained on status boards or log sheets, provided they are compliant with the Health Insurance Portability Accountability Act (HIPAA) and ASF personnel are briefed on use, maintenance and compliance issues.

2.8.2. Senior MSC will implement and establish security procedures to include the following:

2.8.2.1. Anti-hijacking procedures will be followed according to AFI 41-301, *Worldwide Aeromedical Evacuation System,* and Federal Aviation Administration (FAA) directives.

2.8.2.2. Perimeter and Entry Control procedures will be done according to AFI 31-301, *The Air Base Defense*, and AOR Commanders local policies and directives.

2.8.2.3. UXO sweeps and perimeter maintenance will be done according to AFI 32-3001, *Explosive Ordnance Disposal Program*.

2.8.2.4. Handling, securing and processing POWs and criminals will be in accordance with Geneva Convention Rules and Laws of Armed Conflict AFI 51-401, *Training and Reporting to Ensure Compliance with the Law of Armed Conflict.*

2.8.2.5. Handling and storing of weapons and ammunition will be according to AFI 31-301.

2.9. ASF Flight Surgeon.

2.9.1. The flight surgeon will review the patient's record, prescribed treatment and diet, and address any current medical complaints upon arrival with appropriate documentation on the patient's AF Form 3899. The flight surgeon will determine if the patient can begin or continue travel in the patient movement system and coordinate status with appropriate PMRC and Medical Crew Director (MCD). NOTE: A flight surgeon will evaluate the patient's condition every 24 hours, will consult with medical specialists as needed, and will be available on a 24 hour basis.

2.9.2. For extensive documentation, use Standard Form 600, *Health Record-Chronological*, or other locally approved forms. Attach all forms to the AF Form 3899 and transport with the patient.

2.9.3. Doctor's Orders. Physicians will order enroute treatment on continuation sheets attached to the AF Form 3899 and sign the order.

2.9.4. The flight surgeon will make rounds with an ASF nurse once every 24 hours, minimally, updating the AF Form 3899. In the event of a patient status change, report the change through ASF MSC or Medical Regulating Officer for updating TRAC^{2}ES.

2.10. Nursing Services.

2.10.1. ASF nursing services document all patient care on AF Form 3899. All entries will be recorded in ZULU time (example: 1837Z or 0245Z). Charting is required upon admission, once a shift and upon discharge from ASF at a minimum. Triage starts with review of the patient manifest and PMR and continues through the patient's arrival and nursing report. The flight surgeon with assistance of the ASF nurse determines whether each patient can remain in the ASF or must be transferred to the MTF for medical care. Ensure all patients have a patient identification, ID bracelet. Bracelet will include last name, first name, middle initial, last five of SSN (printed or typed).

2.10.2. The flight nurse and ASF nurse will daily count narcotics and record dosage on the AF Form 3899 or PMR.

2.10.3. Patients will not self medicate with controlled medications. It will be the responsibility of the medical personnel in each patient care area (user service, CASF, AE crews, ASF and destination MTF) to administer controlled medications to their patient population. Documentation will be charted in ZULU time on the AF Form 3899. If patient arrives without an AF Form 3899, for example, arrives with a DD Form 602, *Patient Evacuation Tag* or a DD Form 1380, *US Field Medical Card*, information from those documents will be transcribed onto an AF Form 3899 and the original documentation will be attached to the AF Form 3899 and will become a permanent part of the patient's medical record.

2.10.3.1. Patients may self medicate with non controlled medication only when designated by the flight surgeon. Self medication orders will be documented on the AF Form 3899. The ASF nurse with assistance from pharmacy personnel, when available, will provide an adequate supply of medications and an AF Form 3861, Medication Record for identifying dosages and schedules for self administered medication. (intra-theater movement requires a 3 day minimum supply; inter-theater movement requires a 5 day minimum supply). During time of war, intra and inter-theater medication supply levels will be based on command directives. Pharmacy technician will provide patient with instruction and information regarding their prescribed medication. Education will be documented on the AF Form 3899.

2.10.3.2. Provide AF IMT Form 78l, *Multiple Item Description,* as required to fill an inpatient narcotic prescription request. AF IMT Form 781 should be completed by the attending physician.

2.10.4. Prior to departing the ASF, the patient will be assessed for pain and, if required, administered medication within one hour of departure. If possible, delay administering diuretics until after flight.

2.10.5. Narcotics that are unaccounted for will be turned into the pharmacy and documented on AF IMT Form 3859, *Turn-In of Unaccompanied Narcotics*.

2.10.5.1. If controlled medication is stored at a remote location other than a pharmacy, i.e., nurses station, an ASF nurse and another qualified person must count narcotics at change of shift and document on AF IMT Form 579, *Controlled Substance Register*.

2.10.6. When preparing patients for departure the ASF nurse will include as attachment, the Patient Preparation Checklist.

2.10.7. Place all medical records (clinical records, outpatient treatment records, X-rays, and any other pertinent patient information) in an envelope. The following information will be printed on the outside of each patient envelope:

Patient name

Rank or status

Last five numbers of SSN

Cite number for patients without SSN

Nationality (if not a US citizen)

Organization

Date of departure

Destination

All medical records, X-rays, medications and supplies will be placed in a secure records carried and transported to and from the aircraft. This carrier will be exchanged with the MCD at origin and each end of the mission. All information regarding patient information must follow AFI 33-332, *Air Force Privacy Act Program.*

2.10.8. Complete other forms as necessary, including:

2.10.8.1. AF Form 3856, *AE Patient Intake & Output.*

2.10.8.2. AF Form 3857, *AE Patient Medication Requirements* (Physician's orders).

2.10.8.3. AF Form 3861, *Medication Record* - used to document scheduled and PRN medications.

2.10.9. All special diets will be ordered by the physician and documented on the AF Form 3899. Ensure all patients are allocated a meal for flight.

2.11. Medical Logistics.

2.11.1. During peace time operations the ASF property custodian orders medical and non-medical supplies through the medical logistics function of the supporting MTF. Local policies need to be followed regarding item selection, sources of supply, and funding support. Equipment will be requested through the medical equipment management office of the supporting MTF.

2.11.2. During contingency/wartime operations, the ASF property custodian orders supplies using the procedures established by the responsible theater medical logistics offices. These procedures should address the use of WRM, obtaining medical re-supply, joint support activities, and the function of the SIMLM.

2.12. Mission Launch and Recovery. Plans, policies, procedures and processes (P4) will be in place to include the following:

2.12.1. Management and control of medical attendants which includes:

2.12.1.1. Stresses of flight

2.12.1.2. Billeting and recall

2.12.1.3. Patient responsibility of attendants

2.12.2. Inventory and management of special equipment

2.12.3. Delivery and recovery of patient to and from aircraft, including:

2.12.3.1. Medical and medication documentation to Medical Crew Director (MCD)

2.12.3.2. Special diet, patient medical records, x-rays, SF 600

2.12.3.3. Proper handling of litters, NATO carriers and attire

2.12.4. Management of administrative processes including:

2.12.4.1. Reviews of AF Form 3899 and TRAC^{2}ES PMR

2.12.4.2. Preparation of baggage list provided by TRAC^{2}ES and patient baggage tag (DD 600)

2.12.4.3. Anti-hijacking process and presentation

2.12.4.4. Vehicle control including drivers

2.12.4.5. Flight line authorization, chocks and radios

2.12.4.6. Configuration of ambus, ambulance or opportune conveyance

2.12.4.7. Vehicle mechanical and security checks

2.12.4.8. Flight line safety and security

2.12.5. Management of all documentation including:

2.12.5.1. Patient classification changes on PMR (can only be changed by Flight Surgeon)

2.12.5.2. Completion of AF Form 3899 to include vital signs, ensure medications requirements are properly documented on AF Form 3899, AF Form 3857, and AF Form 781, if appropriate or required.

2.12.5.3. Completion of AF 3838 *(DNR)* if required

2.12.5.4. Ensuring adequate medication supply for patient

2.12.6. Briefing of patients scheduled for departure to include:

2.12.6.1. Potential for unscheduled overnight stops

2.12.6.2. Possession of authorized/unauthorized articles

2.12.6.3. Use of restrooms

2.12.6.4. Hand carrying luggage, x-rays, medical records and medications

2.12.6.5. Sequence and order of patient loading

2.12.6.6. Procedure and patient requirements during transport to aircraft

2.13. Conducting Anti-Hijacking Procedures and Security.

2.13.1. All patients, attendants, and their baggage to be placed aboard Air Force aircraft or AMC contract aircraft will be checked by ASF personnel. An ASF representative will provide the MCD with a signed statement listing the names of the individuals searched and stating that anti-hijacking measures have been accomplished. This statement will be accomplished per AFI 13-207, *Preventing and Resisting Aircraft Piracy Hijacking.*

2.13.2. During contingencies, when performing anti-hijacking procedures, personnel will wear a kevlar ® helmet, flak vest and other protective gear. When possible, anti-hijacking should be accomplished in an area away from the ASF.

2.13.3. Inspect patients and attendants either with a hand held or walk through metal detector, X-ray machine or by a physical check. WARNING: electromagnetic interference (EMI) from hand held and stationary surveillance systems interferes with implantable cardiac pacemakers and implantable cadioverter-defibrillators (ICD). Changes in pacing rates, shock, and possible cardiac arrest may occur. Use alternate anti-hijacking procedures for patients and passengers with these medical devices.

2.13.4. Notify security police if suspicious items are found.

2.13.5. Restrict inspected patients and attendants to a holding area.

2.13.6. Inspect all hand carried items.

2.13.7. Honor requests for visual inspection instead of using X-ray or metal detectors.

2.13.8. Competent, non psychiatric patients may keep items such as small pen knives (3 inch blades or less), shaving razors or small scissors.

2.13.9. Identify any patient or attendant showing suspicious behavior.

2.13.10. Arrange for guards to accompany prisoner patients to their destination.

2.13.11. Conduct all inspections with the highest standard of military courtesy.

2.13.12. Exempt classified materials held by official couriers from inspections.

2.13.13. Inform passengers that they can't carry weapons or explosives aboard. If authorized weapons are carried onboard, notify aircrew.

2.14. Baggage Restrictions.

2.14.1. Inform all passengers regarding baggage restrictions and prohibitions, to include the current FAA provisions on liquids, and the general prohibition on bringing weapons and explosives onboard the aircraft.

Chapter 3

FACILITY MANAGEMENT

3.1. Medical Treatment Facility (MTF) and the Co-located ASF.

3.1.1. Medical Support. The MTF provides the co-located ASF with medical, administrative, logistical, pharmaceutical, nutritional medicine, radiology and other support services as needed. (Unless otherwise designated, the Director of Aerospace Medicine has oversight of clinical ASF functions).

3.1.2. Administrative and Logistical Support. The originating or enroute MTF provides medical materiel support for patients transiting the continuum of medical care. The MTF shall provide supplies, equipment, linen, and custodial services and the subsequent accounting for such materiel: IAW AFI 41-209, *Medical Logistics Support.*

3.1.3. Resource Management. The MTF Resource Management Office (RMO) will include reports from the co-located ASF as part of the MTF's reporting requirements. The MTF will assist the ASF with personnel, Unit Manning Documentation (UMD), funding requests and requirements and other services as needed.

3.1.4. TRAC^{2}ES. The MTF will support network and terminal connectivity to TRAC^{2}ES providing patient demographic, transportation and clinical information.

3.1.5. Operational Footprint. The MTF will ensure the ASF has enough physical space to accommodate patient loads, infection control processes, readiness requirements and AE mission or transportation surges.

3.1.6. Vehicles. The MTF vehicle control officer will provide appropriate vehicles for ASF transportation needs and will serve as the liaison to the vehicle operations flight.

3.1.7. Orderly room. The MTF will provide standard orderly room services in support of disciplinary actions, career training and leave monitoring.

3.1.8. The MTF will provide trained personnel for patient loading teams as required.

3.1.9. Scope of Care. ASF personnel provide complex medical-surgical nursing care for patients who have been transferred to the ASF awaiting transportation. Patients on life support systems or cardiac monitors, psychiatric patients and homicidal or suicidal patients are provided care in adjacent civilian facilities or MTF.

3.1.10. Patient movement process is initiated by the MTF by entering patient information into TRAC^{2}ES in the form of a Patient Movement Request (PMR). The PMR is then regulated through the appropriate Patient Movement Requirements Center (PMRC). Information available on the PMR includes:

3.1.10.1. Flight number

3.1.10.2. Aircraft tail number

3.1.10.3. Information in TRAC^{2}ES is subject to change on short notice based on current operational requirements. Changes are updated as quickly as possible, but the PMR may not reflect the most current information available. The MCC will be in contact with the PMRC to ensure the lat-

est information is provided to staff, but some changes do not get communicated until a flight arrives on station.

3.1.10.4. Estimated departure time on originating flights

3.1.10.5. Patient classifications, diagnoses, and requirements for special equipment, diets, ambulance or personnel

3.1.11. Releasing Patients from the AE System. See AFI 41-301, *Worldwide Aeromedical Evacuation System*, provides the current guidance on policies and procedures.

3.1.11.1. Placing Patients on Medical Hold. In the event of changes in the patient's condition, the Flight Surgeon may place a patient on medical hold, not to exceed 72 hours. Patients with severe conditional changes may require admission to an MTF whereupon the flight surgeon will arrange for hospitalization. ASF personnel will notify the PMRC of interruption of patient movement. NOTE: Patients who are removed from the AE system may not resume travel on their original TRAC^{2}ES cite number.

3.1.11.2. RON in the MTF or Other Agency. All RON patients are census assets of the ASF. If patients need to RON in the MTF or other agency while transiting patient movement system, they shall not be formally admitted to the MTF. The MTF flight surgeon or designee will manage the medical care of such patients and will reaffirm their readiness for flight. Patients in RON status at a civilian medical facility may be admitted, but the ASF will retain them as ASF RON patients.

Chapter 4

CONTINGENCY AEROMEDICAL STAGING FACILITY

4.1. CASF will follow ASF guidelines in previous chapters where applicable.

4.1.1. CASF Mission. The CASF is a unique, modular aeromedical staging facility that is designed to support world-wide expeditionary contingencies while itself is supported by a level 3 MTF or higher. The CASF personnel package is composed of three building block UTCs that are combined in various ways to customize the CASF depending on nature and size of mission requirement. It provides patient reception, complex medical-surgical nursing care, limited emergent intervention, and ensures patients are medically and administratively prepared for flight. For planning purposes patient holding times range from 12 hours to 72 hours depending on aircraft availability and patient status. The building-block approach of the CASF allows its size to be scaled according to medical needs, changing requirements, and airlift availability. CASFs can be deployed anywhere in the world. CASFs support combatant commanders, humanitarian/disaster relief operations, the ICMOP and/or potentially homeland security/defense/disaster response missions. Additionally, CASF equipment is composed of four UTCs that can be sized to support the mission requirements. Configurations range from the CASF-BASIC to a CASF+250, with appropriate increases in personnel and equipment.

4.1.1.1. Clinical Nursing Function UTC (FFVNF). This 24 personnel UTC provides the clinical care components to the CASF and is the only UTC that can be deployed independently in support of CASF-BASIC. FFVNF includes a nurse administrator, clinical nurses, medical technicians, and limited technical services, and an administrative technician. Administrative duties are limited to patient support and patient movement. Larger CASF builds require deployment of this UTC in combination with other UTCs to form the various packages. See **Attachment 3**.

4.1.1.2. Command Function UTC (FFVCF). This twelve 12 person UTC package contains personnel with the knowledge, skills, and experience of the patient movement system, and command, communications, and control for a CASF+25 for independent medical care and support. This UTC brings health service administration (MSCs), flight surgeon, physician assistant, mental health nurse, medical services superintendent, logistics, biomedical equipment repair (BMET), pharmacy, and mental health technician support for the mission. It is utilized in building CASF+25, +50, +100, and +250 size facilities. It is absent in the CASF-BASIC package since these services are provided by the co-located MTF, whether a fixed CONUS or deployed MTF such as EMEDS. If BOS is limited, planners should add provisions for personnel with expertise in aircraft ground equipment (AGE) setup and management for generator, electrical grid and lighting. See **Attachment 3**.

4.1.2. CASF-BASIC (Nursing function). CASF-BASIC must be co-located with the medical facility. CASF-BASIC is not equipped for independent medical care and provides only ward support and/or medical billeting for patients transiting the patient movement system. CASF-BASIC provides complex medical-surgical nursing care only and relies on the attached medical facility for dietary, logistics, pharmacy, mental health, physician and administrative services. These functions will be provided by a co-located DoD contingency MTF or CONUS level-3 MTF in support of the COCOM mission.

4.1.3. CASF+25 (Command function). The command function deploys when medical care beyond complex medical-surgical nursing care for a 25-bed configuration is necessary. The CASF+25 provides physician care and additional support for administrative, biomedical equipment repair, logistics,

pharmacy, and mental health functions. CASF+25 requires support for dietary, and critical care nursing.

4.1.4. CASF+50 Consists of a 50-bed configuration with the same support services as the CASF+25.

4.1.5. CASF+100 (Specialty function). Dietary and critical care nursing services are included in a 100-bed configuration. A CASF+100 is capable of functioning on a more independent level, and although utilizes MTF logistics supply line, medical waste management services, and ancillary services is able to function geographically separated from the MTF's.

4.2. Operations. The CASF may be located at major AE or other transportation/patient movement interface points within the theater at tactical or strategic transportation hubs. Upon notification of impending deployment, the unit CASF commander will coordinate with the Medical Readiness Officer and accomplish a pre-deployment review of key documents and responsibilities. The EXORD/OPORD identifies OPCON, TACON, ADCON, mission objectives, rules of engagement, force protection, handling of classified information, hazardous cargo, and other mission specific requirements for the deployment. The theater combatant commander's redeployment order authorizes the redeployment of medical resources.

4.3. Interface with MTF. Upon arrival at the deployed location, the command element of the CASF (Commander, Chief of Medical Services, Administrator, and Chief Nurse) shall contact all MTFs that will be moving patients to the CASF in the AE/transportation system in order to coordinate transportation and continuation of patient care. The executive team must also be familiar with the deployed environment's patient movement items (PMI) program for obtaining and tracking the elements essential to AE operations. Theater policy should be indicated in the OPLANS. In addition to medical relationships, the base commander and airfield manager should be contacted to coordinate BOS (e.g. Air Transport Operations Center [ATOC], Civil Engineering, Communications, Transportation, DFAC and flight safety), and fire and force protection units should be notified of the presence of a CASF on the base.

4.4. Command and Control.

4.4.1. The CASF will be designated a squadron under the expeditionary or fixed medical group Commander. A CASF-BASIC shall be under the command of the EMEDS/MTF Commander and follow the EMEDS/MTF command structure as outlined in the OPORD.

4.4.2. The CASF will fall under TACON of the Air Force AEW/AEG Commander or the commander of the MTF (if other than Air Force) in accordance with the OPORD, which will define specific command relationships. OPCON will remain with the theater Air Force commander. For AFRC personnel, under full mobilization, full ADCON authority goes to the Commander of the Air Force Forces (COMAFFOR). Under less than full mobilization, the COMAFFOR receives specified ADCON that includes Uniform Code of Military Justice (UCMJ) authority, force protection requirements, and other specified authorities written in G-series orders. AFRC retains all other ADCON authorities (AFTTP 3-42.1). Intelligence reports, including medical intelligence, will be forwarded through the medical group. All medical reports such as MEDRED-C and SITREPS are submitted in accordance with AFI 10-206, *Operational Reporting* and specific combatant commander, JTF, and AFFOR guidance according to MAJCOM directives.

4.4.3. The senior CCATT member will coordinate with the CASF commander for optimal patient care and mission efficiency; however C2 for CCATT personnel will remain with the Aeromedical Evacuation Squadron commander, IAW CCATT CONOPS.

4.5. Communications/Computer Systems Support. The CASF will deploy with radio equipment that will be operated by CASF personnel. The radio equipment will be the Air Force current model and type with appropriate encryption capability as defined by the combatant commander. This radio system is operationally focused to manage intra-CASF communications and support flight line patient movement operations. Support for this radio system will be required from base and/or expeditionary combat support communication resources for initial setup as well as ongoing support for telephone, local area network (LAN), and internet and worldwide web access. Health services technicians and senior leaders should be trained in the application and operation of required systems, including, but not limited to Global Emergency Management System (GEMS), TRAC^{2}ES, Secure Telephone Equipment (STE), Defense Messaging System (DMS), Secret Internet Protocol Router Network (SIPRNET), Global Decision Support System (GDSS) and Security Management System (SMS).

4.6. Security. CASF personnel and equipment are non-combatant assets, though personnel may be armed as dictated by theater instructions. Facility security for asset protection and entry control, personal protection, and patient protection is performed by armed CASF personnel IAW the Laws of Armed Conflict and Geneva Conventions. Security for CASF personnel and patients against enemy aggressors is the responsibility of the host unit.

4.6.1. Upon arrival, the CASF/CC will establish Plans, Policies, Procedures and Processes (P4) for Weapons Handling and Storage Procedures. (Weapons are defined as: Any device which may be used to inflict injury or death to include (but not limited to) firearms, explosives, ammunition, and knives (Including multi-purpose tools, aircrew knives, etc). See AFI 31-301 *Air Base Defense* for additional guidance). P4 for weapons handling and storage procedures will include:

4.6.1.1. Ensuring the proper control of weapons when temporarily stored in the facility

4.6.1.2. Outlining the proper storage and distribution procedures for weapons that are CASF assets. Establish secure site for CASF defensive weapons and ammunition

4.6.1.3. Establishing clear policies defining personnel authorized to carry weapons: members of Security Forces (SF) or Military Police (MP) performing official duties are authorized to carry a firearm while in the CASF. CASF Commander or Wing Commander may issue written authorization to other individuals with specific mission requirements to carry weapons into the CASF.

4.6.1.4. Determining and establishing a secure weapons storage area and log. Ensure that persons unauthorized to carry firearms or other weapons in the facility are identified and disarmed

4.6.2. P4 will be implemented relative to the establishment and supervision of entry control points (ECP) to include entry, exit and firearm management. ECP policy will include:

4.6.2.1. Personnel identification (photo ID, passwords, protective barriers, etc)

4.6.2.2. Positioning of clearing barrel, and weapons

4.6.2.3. Collection, securing and storing patient weapons to include firearms, grenades and explosives. Weapons will be identified and inventoried using AF IMT 1297

4.6.2.4. Establishing and managing the disposal of collected weapons and ammunition with Security Forces and/or armory

4.6.3. P4 will be established for the temporary storing of weapons for redeploying CASF personnel to include:

4.6.3.1. Securing and reclaiming weapons to and from Security Forces

4.6.3.2. Securing weapons in approved travel case or storage

4.6.4. P4 will be firmly established regarding the issuance of firearms to unexploded ordinance (UXO) sweep teams, to include:

4.6.4.1. Number of weapons and ammunition issued to CASF members

4.6.4.2. Ascertaining the weapons qualification of the individual.

4.6.4.3. Proper loading and clearing of weapons

4.7. Force Protection. Civil Engineering has the primary responsibility to provide facility hardening for the CASF and ancillary structures associated with the CASF (e.g. logistics storage, laundry, latrines, anti-hijacking areas, patient leisure areas). In the event CE does not provide support, CASF personnel will harden their own facilities. See AFMAN 10-100 for additional guidance.

4.8. Anti-Hijacking. Anti-hijacking measures will be accomplished on any patients, non-medical attendants, and/or baggage transiting the ASF. CASF personnel will deploy with appropriate personal protective equipment (PPE), including helmet, eye shields, gloves and interceptor vests; and wear the PPE while performing anti-hijacking duties.

4.9. Training. Unit training and deployment requirements will be maintained IAW AFI 41-106 *Medical Readiness Planning and Training and AFMAN 10-100, Airman's Manual*. The CASF mission is a unique role integral to the successful movement of patients. All personnel assigned to CASF (FFVCF, FFVNF & FFVSF) will attend CASF course at Sheppard AFB TX within their training window before their AEF bucket of assignment is in the window for deployment cycle. Individual readiness skills verification (RSVs) and other AFSC-specific training requirements will be current prior to attending CASF training. Training requirements will be current prior to deployment. Smaller personnel packages supporting expeditionary operations will require personnel to perform a variety of functions (multi-tasking) which may not be in their specific AFSC responsibilities. Accordingly, training shall emphasize a breadth of talents, skills and be appropriate to the mission. A flexible approach to patient care, movement, staging, administration, facility management, and security is essential for success. AFI 41-106 remains the governing AFI for CASF training.

4.10. Expeditionary Medical Logistics.

4.10.1. Expeditionary Medical Logistics. Orders will flow from the deployed unit through the operations group to the CONUS sustaining base. The CONUS sustaining base receives orders from deployed units and takes necessary actions to ensure 100% of all orders are transmitted to vendors/ depots, are immediately purchased, packed, marked, and shipped so that the materiel is received by the deployed unit. The Single Integrated Medical Logistics Management (SIMLM) system is the source for joint medical supply needs. Until SIMLM is fully implemented, additional FFVS1 CASF expendable medical supply packages could be utilized for re-supply of expendable items. The re-supply chain of medical and administrative equipment and expendable materials will follow the normal channels through the affiliated MTF.

4.10.2. The facility manager is responsible for making arrangements for proper disposal of biomedical (red bag) waste with the EMEDS or the MTF.

4.10.3. Medical logistics personnel must be familiar with the many aspects of the theater's PMI program, to include obtaining, storing, maintenance, tracking, and recycling practices of the PMI commodity. Asset visibility is essential for timely AE support to prevent degradation of forward element medical capability. Personnel must work with the AE community in tracking assets for optimal utilization.

4.11. Forms Adopted.

AF Form 1052, Envelope for Storing Patient's Valuables

AF Form 1053, Record of Patient Storing Valuables

DD Form 600, Patient Baggage Tag

SF 600, Health Record—Chronological

AF Form 2383, Prescriber's Information

AF Form 1297, Temporary Issue Receipt

AF Form 3851, Patient Baggage Data

AF Form 3861, Aeromedical Evacuation Patient Medication Record

AF Form 3856, Aeromedical Evacuation Patient Intake/Output

AF Form 781, Multiple Item Prescription

AF Form 579, Controlled Substance Register

DD Form 1348-6, Single Line Item Requisition System Document (Manual Long Form)

AF Form 129, Tally In/Out for Rations

AF Form 79, Cash Collection Record

AF IMT 1297 Temporary Issue Receipt

AF Form 3859, Turn in of Unaccompanied Narcotics

AF Form 3851, Patient Baggage Data

AF Form 3899, Patient Movement Record

AF Form 3899A, Patient Movement Record Progress Notes

AF Form 3899B, Patient Movement Physician Orders

AF Form 3899C, Patient Movement Physical Assessment

AF Form 3899I, Patient Movement Medication Record

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Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION.

References

AFMAN 10-100 *Airman's Manual*

AFI 10-206, *Operational Reporting*

AFPAM 10-219v5, *Bare Base Conceptual Planning Guide*

AFH 10-222v1, *Guide to Bare Base Development*

AFI 10-701, *Operational Security (OPSEC) Instructions*

AFMAN 23-110, *USAF Supply Manual*

AFMAN 24-204, *Preparing Hazardous Material for Military Air Shipment*

AFJMAN 24-306 *Manual for the Wheeled Driver*

AFI 31-301, *Air Base Defense*

AFI 31-304 and AR 190-8, *Enemy Prisoners of War, Retained Personnel, Civilian Internees and Other Detainees*

AFMAN 32-4005, *Personnel Protection and Attack Actions*

AFPD 34-5, *Mortuary Affairs*

AFI 36-3003, *Military Leave Program*

AFPD 40-2, *Radio Active Materials (Non-Nuclear Weapons)*

AFPD 40-3, *Family Advocacy Program*

AFI 41-106, *Medical Readiness Planning and Training*

AFI 41-115, *Authorized Health Care and Health Care Benefits in the Military Health Services System (MHSS)*

AFPD 41-2, *Medical Support*

AFPD 41-3, *Worldwide Aeromedical Evacuation*

AFI 41-209, *Medical Logistics Support*

AFI 41-301, *Worldwide Aeromedical Evacuation System*

AFI 41-303, *Aeromedical Evacuation Dietetic Support*

AFI 41-307, *Aeromedical Evacuation Patient Considerations and Standards of Care*

AFI 41-309, *Aeromedical Evacuation Equipment Standards*

AFI 51-401, *Training and Reporting to Ensure Compliance with the Law of Armed Conflict*

AFH 41-318, *Ambulance Bus (AMBUS) Training Standards*

AFI 46-101, *Nursing Services and Operations*

DOD 4515.13R, *Air Transportation Eligibility*

Joint Pub 4-02, *Health Services Support*

AR 190-8, *Enemy Prisoners of War*

TTP 3-42.5, *Aeromedical Evacuation*

Abbreviations and Acronyms

ADCON—Administrative Control

AE—Aeromedical Evacuation

AEF—Aerospace Expeditionary Force

AECT—Aeromedical Evacuation Control Team

AFMS—Air Force Medical Services

AFI—Air Force Instruction

AFJI—Air Force Joint Instruction

AFMAN—Air Force Manual

AFJMAN—Air Force Joint Manual

AFM—Air Force Manual

AFPD—Air Force Policy Directive

AFRIMS—Air Force Records Information Management System

AMBUS—Ambulance Bus

AOR—Area of Responsibility

ARC—Air Reserve Components

ASF—Aeromedical Staging Facility

ASTS—Aeromedical Staging Squadron

BOS—Base Operating Support

CASF—Contingency Aeromedical Staging Facility

CCATT—Critical Care Air Transport Team

COMAFFOR—Commander of the Air Force Forces

CONOPS—Concept of Operations

CONUS—Continental United States

DFAC—Dining Facility

DMS—Defense Messaging System

DNR—Do Not Resuscitate

DOD—Department of Defense

ECP—Entry Control Point

ECS—Expeditionary Combat Support

EMEDS—Expeditionary Medical Support

EXORD—Execution Order

EPW—Enemy Prisoner of War

ETA—Estimated Time of Arrival

ETD—Estimated Time of Departure

FAA—Federal Aviation Administration

FASF—Fixed Aeromedical Staging Facility

FS—Flight Surgeon

GEMS—Global Emergency Management System

GDSS—Global Decision Support System

GPMRC—Global Patient Movement Requirements Center

HIPAA—Health Insurance Portability and Accountability Act

HUMRO—Humanitarian Relief Operations

IAW—In Accordance With

ICMOP—Integrated CONUS Medical Operations Plan

JPMRC—Joint Patient Movement Requirement Center

JTF—Joint Task Force

LAN—Local Area Network

MAJCOM—Major Command

MASF—Mobile Aeromedical Staging Facility

MCC—Medical Control Center

MCD—Medical Crew Director

MDG/CC—Medical Group Commander

MP—Military Police

MRE—Meals Ready to Eat

MSC—Medical Service Corps

MTF—Medical Treatment Facility

OPCON—Operational Control

OPORD—Operational Order

PMI—Patient Movement Items

PMR—Patient Movement Request

POW—Prisoner of War

PPE—Personnel Protective Equipment

RDS—Records Disposition Schedule

RMO—Resource Management Office

RON—Remain Overnight

SF—Security Forces

SIMLM—Single Integrated Medical Logistic Management

SIPRNET—Secret Internet Protocol Router Network

SITREP—Situational Report

SSN—Social Security Number

TACON—Tactical Control

TDY—Temporary Duty

TRAC^{2}ES—TRANSCOM Regulating and Command and Control Evacuation System

TRANSCOM—Transportation Command

TPMRC—Theater Patient Movement Requirement Center

UMD—Unit Manning Document

UTC—Unit Type Code

UXO—Unexploded Ordinance

WRM—War Reserve Materiel

Attachment 2

CONSIDERATIONS FOR CASF SETUP

A2.1. Facility Layout

A2.1.1. Criteria:

A2.1.1.1. Safety

A2.1.1.2. Comfort

A2.1.1.3. Patient Categories

A2.1.1.4. Special Needs

A2.1.1.5. Infection Control/Sanitation

A2.1.1.6. Logical

A2.1.2. Equipment and Supplies

A2.1.2.1. Unpack/inventory pre-positioned War Reserve Material (WRM)

A2.1.2.2. Set-up and position in CASF

A2.1.2.2.1. Accomplished using tech orders

A2.1.2.2.2. Equipment should be checked and calibrated by Medical Equipment Repair Tech

A2.1.3. Facility Traffic Flow

A2.1.3.1. Set entrance and exit points for patients

A2.1.3.2. Separate entrance for deliveries of facility supplies

A2.1.3.3. Emergency egress routes in event of fire, bomb threat, or bug-out

A2.1.4. Reception Area/Outbound Staging

A2.1.4.1. Located near Entry Control Point (ECP)

A2.1.4.2. Room for briefings patients

A2.1.4.3. Access to administrative functions

A2.1.4.4. Located near the exiting ECP

A2.1.4.5. Litter stanchions/NATO Gurneys/Litters

A2.1.5. Contingency Aeromedical Staging Squadron (CASF) Control Center/ Administrative

A2.1.5.1. Communication and runner capabilities

A2.1.5.2. Secure Access

A2.1.5.3. Out of traffic pattern

A2.1.5.4. Limited traffic

A2.1.6. Medical Logistics

A2.1.6.1. Located within the facility

A2.1.6.2. Must be out of the patient flow area

A2.1.6.3. Must have ability to secure and control access

A2.1.7. Baggage holding area

A2.1.7.1. Secure area that can be locked

A2.1.7.2. Patient access allowed only with escort

A2.1.8. Weapons

A2.1.8.1. Storage

A2.1.8.2. Handling

A2.1.8.3. Cleaning

A2.1.8.4. Accountability

A2.1.9. Special Area for Enemy Prisoner of War (EPW)

A2.1.9.1. Separate from our troops

A2.1.9.2. Security at all times

A2.1.9.3. Security Provided by originating facility

A2.1.10. Life Skills Section

A2.1.10.1. Separate from other wards

A2.1.10.2. Contains both litter and ambulatory patients

A2.1.11. Nurses Station(s)

A2.1.11.1. Number determined by size/census

A2.1.11.2. Less stable patients in clear view

A2.1.12. Treatment/Isolation areas

A2.1.12.1. Private area out of view of other patients

A2.1.12.2. Separate area for highly contagious patients

A2.1.13. Staff Lounge

A2.1.13.1. Staff rest/dining area

A2.1.13.2. Separate from patient dining

A2.1.14. Ambulatory care area

A2.1.14.1. Separate section for mental health

A2.1.14.2. Near comfort areas

A2.1.14.2.1. Latrines

A2.1.14.2.2. Dining facility

A2.1.14.3. Near diversionary areas

A2.1.14.3.1. Television

A2.1.14.3.2. Magazine/book area

A2.1.14.4. Provide chairs/litters for comfort

A2.1.15. Pharmacy/Nutritional Medicine

A2.1.15.1. Close proximity to patient areas

A2.1.15.2. Pharmacy must be secure with controlled access or a lockable vault/safe

A2.1.15.3. Nutritional Medicine requires limited access

A2.1.16. Temporary Mortuary

A2.1.16.1. Well ventilated, cool area away from patient care

A2.1.16.2. Located in separate tent or other down wind

A2.1.16.3. CASF personnel will hold until arrangements are made to transport to Services' Prime Ribs or Expeditionary Combat Support (ECS)

A2.1.17. Building of Opportunity:

A2.1.17.1. Can be any hardened facility that is available for use

A2.1.17.2. Usually located on or near the flight line

A2.1.17.3. Electricity and lighting are essential and must be 50-60Hz 110-120 volts with adequate outlets for servicing electronic patient equipment

A2.1.17.4. Lighting must be adequate to assure safe movement of patients and personnel in the facility

A2.1.17.5. Building should be level with the ground

A2.1.17.6. Second floor location is unacceptable

A2.1.17.7. Free of toxic contamination

A2.1.17.8. Safe heating/cooling is required to maintain the facility temperature within a temperature range, between 68-80 degrees F

A2.1.17.9. Security and safety should be considered so that hardening of the facility can be accomplished if necessary

A2.1.17.10. The roof must be waterproof, the floor hardened and without risk of flooding

Attachment 3

CASF UTC BUILD

CASF-BASIC = 1 FFVNF

CASF+25 = 1 FFVNF + 1 FFVCF

CASF+50=2 FFVNF+1 FFVSF

CASF+100=3 FFVNF+1 FFVCF+1 FFVSF

CASF+250=5 FFVNF+2 FFVCF+3 FFVSF

CASF UTC Build; Fig 1

UTC	*Title*	*AFSC Requirements*
FFVNF	Clinical Nursing Function	1 - 46A3, 5 - 46N3, 1 - 4A071, 4 - 4N071, 12 - 4N051, 1 4A051
FFVCF	Command Function	2 - 41A3, 2 - 48G3, 1 - 46P3, 1 - 42G3, 1 - 4A271, 1 - 4C051, 1 - 4C071, 1 - 4A171, 1 - 4N091, 1 - 4P071
FFVSF	Specialty Function	1 - 41A3, 1 - 46N3E, 1 - 46P3, 1 - 48R3, 2 - 4A051, 4 - 4N051, 1 - 4N071, 1 - 4D071, 1 - 4C051, 2 - 4A151